Comments from the Health Administration Center (HAC) on 31 CFR Part 210, Federal Government Participation in the Automated Clearing House; Proposed Rule

Section III.B. Vendor Payments, Enrollment, and Relationship to Other Regulations

The NPRM acknowledges that the primary reason for non-use of EFT is non-receipt of remittance data with the payment. Vendors are unable to reconcile their account receivables. The NPRM seeks comments and suggestions on what can be done to make improvements. The four questions posed in the NPRM are listed below, followed by HAC's response:

1. What factors contribute to the non-receipt of remittance data (e.g., customer demand, costs)?

The first is technology. There must be a way to associate the EFT payment to the remittance data. In health care, this can be done using the X12 835 transaction. However, this transaction is not widely used due to lack of standardization within the health care industry. Plus, many vendors or their banks are not technologically ready to receive an electronic remittance advice (ERA). Implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may help reduce these barriers. The second is that there are both business and technological issues in the banking industry as banks are not able or not willing to accept the 835 and pass the remittance data on to the vendor. A third possible barrier may be cost. It is unknown at this time how costs for generating an ERA will be passed on to the customer by the bank. A fourth barrier may be lack of data security.

It should be noted here that HIPAA addresses this issue only from the health care payer and provider standpoint. HIPAA does not include the banking industry. If banks are not required to accept the 835, the barriers that now exist for health care payers and providers will continue. Is it possible for Treasury via this NPRM to require banking institutions to adhere to NACHA Rules?

2. What are the key reasons why EDI has not been adopted widely by the financial industry?

As a health care payer, we are not able to answer this question. If we relate it to health care and EDI, then we can say with some confidence that the major reasons are: lack of understanding regarding the benefits of EDI (lower costs, faster processing times, etc.); lack of standards (there are approximately 400 different proprietary standards in use by those who are presently engaged in health care EDI); lack of hardware and software due to the costs of initial set-up. It is possible some of these reasons are applicable to financial EDI. Health care is working to overcome these reasons for non-use through education and legislation. HIPAA requires ALL payers to be able to receive claims from and transmit claims to providers via a standardized format. Providers are not required by law to submit claims via EDI, but some large payers are considering ways to encourage this, such as charging a fee to process paper claims. Another way to encourage use is that the standards required by HIPAA may be made available to payers and providers at no cost.

The issue here is that health care payers are mandated to use the X12 835 per HIPAA, but there is no mandate for financial institutions to use or accept the 835. There needs to be a coordination of effort between the financial and health care industries to make EFT and ERA transactions as attractive and easy to implement as possible. The first step would be a standard format.

3. Does the approved amendment to the NACHA ACH Rules (effective 9/18/98), which requires the RDFI to provide remittance information upon request, adequately address vendors' concerns?

The amendment is a good beginning, but there are still many unanswered questions regarding implementation. What format(s) will be used? How will the EFT payment be reassociated with the remittance advice? Will the remittance advice be via paper or electronic? Will the receiver

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have a choice (paper vs electronic)? Will there be charges for this service? If so, how much? Will the banking community work with receivers to ensure the transaction meets the needs of the receiver, and on implementation planning? It is our opinion that a cooperative effort is needed in order to make the amendment a useful tool. We also believe that a regulatory correlation between HIPAA and the NACHA ACH Rules and this amendment in particular is needed. [See response #1 above.] Can this NPRM serve in that capacity?

4. What alternative approaches/solutions are there to remedy this problem?

Some of our suggestions are included in the above responses: consider a standard format for EFT/ERA transactions, preferably X12 835; encourage a coordination of effort between banks and customers in implementing the amendment to Article Four of the ACH Rules; and establish regulatory ties between HIPAA and other regulations such as this NPRM that will enable the health care industry to proceed with EDI solutions that have the full support of the banking industry. Other suggestions are that if the NACHA ACH Rules are adopted, that this regulation include methods to ensure compliance by all federal agencies; and that we not pursue EFT too aggressively until the ACH/NACHA, etc. authority is effective.

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Comments: We regret these comments are late. Please accept and consider them.

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